Pricare, PA

Patient Registration

Patient Name:			Date of Birth		SSN
Address			City	State	Zip
Sex	Marital Status M S D W	Race:	Drivers License #	Preferred Language	Pharmacy
Home Phone		Cell Phone		Email Address	
May We Contact You By: ○ Home Phone ○ Cell Phone ○ Work Phone ○ Mail ○ Email		If unable to speak with you may we leave a message: □ Home Phone □ Cell Phone □ Work Phone		If we can leave a message please list names of people we may leave it with	

Employer Information

Employer Name:	Employer Address:	
Work Number	Occupation	○ Full Time ○ Part Time

Emergency Contact

Name	Relationship	Cell Phone	Home Phone
Name	Relationship	Cell Phone	Home Phone

Insurance Information

Policy Name	Contract Number	Group Number	
Subscriber Name on policy	Subscriber DOB	Subscriber SSN	Relationship

Second Insurance

Policy Name	Contract Number	Group Number	
Subscriber Name on policy	Subscriber DOB	Subscriber SSN	Relationship

Responsible Party if Patient is a Minor

Name	SSN	DOB	
Address	City	State	Zip
Home Phone	Cell Phone	Relationship	

Financial Responsibility-Consent To Treatment- Release of Medical Information

I, the undersigned, consent to treatment necessary for the care of the above patient. I acknowledge full financial responsibility for any services rendered and understand that payment of charges incurred in the office is due at that the time of service. I also understand that charges not covered by any insurance remain my responsibility. In the event this account is not paid within 90days, the undersigned agrees to any and all reasonable cost associated with collection of this debt and I hereby waive all rights of exemption under the Constitution of the State of Alabama.

Signed_____ Date_____

Pricare, PA
Office Billing Policy

This office accepts assignment of benefit from most insurance companies. Verification of your insurance coverage must be obtained before assignment will be followed. We need copies of your insurance cards.

It is important to know, however, that your group plan is a relationship between you and your insurance company. **THE ULTIMATE RESPONSIBILITY FOR PAYMENT OF SERVICES IS WITH YOU**. Until coverage is verified, you will be responsible for payment of services.

Generally, most insurance plans have deductable clauses. Therefore any deductable portion of the bill is your responsibility, as well as any co-pay that is not covered by your insurance. We ask that co-pays, deductibles be paid at each visit, unless other arrangements are made.

Your insurance will be billed for your services each billing cycle. If your insurance fails to pay within a reasonable time (45days of billing) we will bill you for information only, at this time you would need to contact your insurance company. Failure of a claim to be paid within 60 days of billing will become your responsibility.

At the time that all insurance payments have been received, if there is an overpayment we will either issue a check or apply that credit to your account. We will be reconciling your account as each payment is made, if there is a balance owed, payment can be made by cash, check, credit card or money order.

Agreement To Pay: The undersigned accepts the fee charged as lawful debt and promises to pay said fee as outline above. If the account is sent to collections, the undersigned will also be responsible for collection fees, attorney fees, and court cost if necessary, waving now and forever the right to claim exemption under the constitution and the laws of the State of Alabama, or any other state.

_____ _____

Patient Name (please print) Date

_____ _____ _____

Responsible Party Signature Relationship to Patient Responsible Party SSN

Pricare, PA
Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in my treatment directly and indirectly
- Obtain payments from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your Notice of Privacy Practices, containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at PO Box 789, Alexander City, AL 35011, to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Authorization to Disclose Health Information
(emergency contact is also authorized to receive health information)

Name	Relationship	Phone

I wish to be contacted in the following manner (check all that apply):

Home/Cell ___May we leave a message with detailed information
___Leave a message with call back number

Work ___May we leave a message with detailed information
___ Leave a message with a call back number

_____ _____
Patient's Name/Responsible Party (print) Relationship to Patient

_____ _____
Patient's /Responsible Party Signature Today's Date

Pricare , PA

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name | Date of Birth | Social Security Number

Patient Address

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form.

In accordance with **AL** State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. PRICARE PA uses SureScripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized to PRICARE PA.
2. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc. to PRICARE PA
3. I have the right to revoke this authorization at any time by writing to PRICARE PA. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.
6. This authorization expires one year from the date of my signature below.
7. THIS AUTHORIZATION DOES NOT AUTHORIZE PRICARE PA TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

Signature of patient or representative authorized by law | Date

Relationship to Patient | Interpreter, if utilized

Witness Signature

Patient Pulmonary Evaluation Questionnaire

Name_____DOB_____

Please answer the following questions as they apply to you

Have you ever smoked? Yes No

Do you have allergies or currently taking allergy medication? Yes No

Have you ever seemed to be short of breath during normal activity? Yes No

Do you have trouble breathing while participating in athletics? Yes No

Have you ever worked in Cotton Mills or around Asbestos or other chemicals? Yes No

Have you ever worked in Rock Quarries, Coal Mines, etc? Yes No

Have you ever had occupational exposure to dust, pesticides, etc? Yes No

Have you ever been exposed to second hand smoke? Yes No

Are you on Home Oxygen? Yes No

Have you ever seen a Pulmonologist? Yes No

Have you ever had a Pulmonary Function Test? Yes No